Solutions for Keeping Seniors Home for Life
Answers from the Private Sector

Chairperson and Members of the White House Conference on Aging Policy Committee:

My name is Mark Stanley. I, along with my wife, own Home Instead Senior Care (HISC) in Northwest Arkansas. HISC provides non-medical care for the elderly such as meal preparation, light housework, medication reminders, incidental transportation, etc. There are currently over 500 HISC locations in four countries. We are currently enjoying our 5th year of business. Formerly, I have 5 years of experience as a home health physical therapist in the Dallas-Fort Worth area. During these years I've witnessed and helped find viable solutions in literally hundreds of in-home care situations as a medical professional, a non-medical caregiver and a business owner. I am also a member of National Private Duty Association.

Problems/Barriers to affordable in-home care in the private sector:

I. Lack of knowledge and education for those who advise seniors in need of care.

- Structured, non-medical home care is relatively new in long term care
- Physicians and other advisors often do not present this solution
- Institutionalization does **not** equal 24 hour personalized care
- Structured, In-home care provides the most coverage for the least cost

Until recently structured, non-medical home care did not exist. Now it does, yet the flexibility and cost efficiency of this option is often not well understood by those advising seniors of long term care options. For example, when a physician advises a patient that they need 24 hour care to go home from the hospital, the high cost of around the clock home care often leaves no option in the patient's mind other than institutionalization, where it is assumed 24 hour care is provided. This is rarely the case. In Arkansas, the personalized, one-on-one care provided in a nursing home is generally less than 3 hours per day at about $116/day. Articles in local newspapers have detailed how nursing facilities struggle to meet this minimum requirement. For that same money a non-medical agency can provide over 8 hours of one-on-one care, and an independent caregiver, if the patient chooses that option, can provide even more. I believe undue strain is placed on patients and their families when 24 hour care is mandated without fully exploring all the options to (1) keep the patient in the home and (2) reduce the cost whenever possible. If any person has not had experience and training in home care and home safety assessment, they usually are not qualified to make care requirement decisions.

Ways to reduce costs.

1. As an example, if the patient is relatively safe for 2 - 3 hours at a time with a safety call button at home, caregiving can easily be scheduled in shifts with a 2 - 3 hour break for which the patient does not have to pay. Staggered shifts like this is a great way to cover the maximum number of hours with the fewest possible dollars.

2. If the patient sleeps through the night, why have 24 hour care?

3. If the physician believes the need for a large amount of care may be temporary, make sure the patient and family are aware of this. It is common to keep services in place, because the doctor ordered it. Keeping lines of communication open can save hundreds of dollars, if not thousands of dollars. Often a short burst of extensive care costs can be absorbed in a family budget if the hours can be cut as the patient's condition improves.

Solutions:

We need an education initiative to inform advisors, doctors and family members of the benefits, relative low cost and flexibility of structured, non-medical, in-home care. Referrals by physicians to facilities in which they have a personal association or financial interest should be strictly forbidden.

II. Lack of standardization and recognition for the emerging non-medical home care industry by state and federal governments.

- Forcing non-medical agencies to submit to medically driven home health regulations cause the service to become cost prohibitive.
- If we are to be regulated, we need a category of licensure that fits our business model.

Complicated federal Medicare standards and policies developed for yesterday's elderly population are being forced onto an emerging and specialized private duty industry driven by today's exploding population. Medically focused regulatory laws, enacted for federal programs, do not foster non-medical, modern day models that address the incredible demand for in-home domestic and personal care services. Regulatory mandates add to an increase in administrative and paperwork costs. Medical-model regulation restricts the flexibility required to provide adequate services to the elderly. Agencies find themselves spending more time on paperwork than providing direct services.

If the non-medical industries are to be regulated by the state or federal governments, then the rules need to be specific to this industry and involve the industry leaders in their construction.

Solution:
Follow the lead of states that have forged a licensure category for non-medical care, separate and apart from licensed home health agencies. Enact reasonable guidelines that protect the consumers (such as criminal background checks and insurances) while not over burdening the agency to the degree that the services become unaffordable. An example of this burdening is requiring an unnecessary registered nurse on staff to supervise non-medical tasks.

III. Lack of standardization and flexibility in the language of Long Term Care Insurance policies and in the practices of the insurance providers' claims departments.

- The landscape of private LTC insurance lacks standardization and is confusing and frustrating to the average consumer.
- The language in many LTC policies unnecessarily restricts seniors to medically natured businesses for care.
- These restrictions drive up costs of home care and lead to a bias of institutionalization that is mirrored in Medicare/Medicaid.

A minority of Americans plan for their long term care needs either by saving adequately or purchasing a long term care insurance policy. Often those who do are unpleasantly surprised when it comes time to make a claim on these policies. Many insurance companies have followed the federal governments lead by requiring that all in-home care (even that of the non-medical variety) be provided only by full blown, licensed home health care agencies. Due to the regulation they operate under, the licensed agencies that do provide non-medical care are relatively expensive.

This has the result of decreasing the amount of care a person can receive from their policy's daily limit. In many cases, the availability of licensed agencies that are able and willing to provide this hourly care is limited. What good is having a benefit if the agencies are not available to provide the service? The great majority of licensed home health agencies in Northwest Arkansas focus solely on medical, Medicare driven service (as they were designed to do). Forcing a client to use a medically designed business to fill a non-medical need is cumbersome, financially inefficient and often infuriating.

Solution:
Much like Medicare Supplement policies, LTC insurance policies need to be standardized across all states, times and companies. This will decrease confusion and allow those who do plan ahead to know exactly what kind of protection they are buying.

LTC insurance providers need to allow the consumer more flexibility in how their claim dollars are spent. Let the consumer decide between and a non-medical agency or a licensed home health agency.

IV. Increasing use of independent contractors

- Independent caregivers are the most abundant source of in-home care.
- Much of this business is conducted in an underground economy where few safeguards are in place and taxes are not paid.
- Seniors rarely understand the risks and responsibilities of being an employer.

The increased use of independent contractors also places the elderly at greater risk. While legitimate home care agencies promote the use of safeguards such as proper screening, training, bonding, worker's compensation, liability insurance and supervision, rarely do such safeguards exist for independent contractors. Deficient in accountability and standards, independent contractors can easily place vulnerable and frail elderly at risk for abuse and financial exploitation.

Use of independent contractors often leads to a loss of state and federal revenue. Increasing costs drive more elderly home care recipients to employ underground workers and independent contractors. Unlike a reputable home care agency that withholds payroll taxes, this responsibility falls on the consumer who contracts with an independent contractor. Due to lack of awareness or intimidation of IRS rules, the elderly fail to do so. Thus, independent contractors are paid "under the table" and state and federal tax revenues are lost.

Independent contractors who do not report income will not accrue Social Security credits. While legitimate agencies routinely make these contributions, "under the table" jobs offer a temporary incentive that avoids paying into this system. Over time an independent contractor will gradually lose the ability to regain Social Security credits, and not until retirement will the reality of the decreased benefits or ineligibility become apparent.

This is a barrier to our business due to the incredibly high demand for reliable and compassionate caregivers. For many, the lure of immediate, extra money supercedes any thought of future security and current legality. We lose many a caregiver in this fashion and our consistency of care suffers.

Solution:

Independent contractors will always exist in this industry. As long as they 'play by the rules' they are sometimes the best option. Further education like that provided by the Schmieding Center will educate seniors and workers alike of the risks and benefits (i.e. reduced cost). Over burdening legitimate agencies with unnecessary regulations widens the gap in cost between a supervised, insured caregiver from an agency and an independent contractor.

V. Lack of funding commitment for prevention of hospitalization

- Medicare and Medicaid is a strictly reactive system relying on high priced personnel to respond to a medical need
- Lower priced non-medical care giving could easily prevent many events that lead to hospitalization and institutionalizations.
- The current Medicare/Medicaid system has an inherent bias toward institutionalization and other high cost methods of providing care.

American seniors are caught in a reactive health care system. So often, institutionalization follows a hospitalization that follows a preventable event such as a fall in the home. Consider this example:

When I worked as a physical therapist, Medicare paid roughly $100 for every 45 minute visit I made to a patient's home. Of that $100, I received $45 to $55 for my skilled service and the rest went to administrative costs, paperwork costs and profits for the home health agency.

That same $100 will pay for a **fractional** day in a nursing home where less than 3 hours of one-on-one care is required per day along with room and board.

In this area, my company could take that $100 and provide 7 hours of one-on-one personalized care that could go a long way towards prevention of unnecessary injuries and hospitalization events. For example, many hospitalizations could be prevented by proper medication reminder visits. Those 7 hours could be split into 2 shifts to help a person out of bed in the morning, and then make sure they were in bed safely at night.

Solution

Am I saying that skilled care in the home or in an institution is not valuable? Of course not, but if we as a country are serious about keeping people at home and allaying rising health care costs, there's going to have to be some redistribution of monies away from high priced reactive measures to more affordable preventative measures. Structured, non-medical homecare is just such a method.